FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0000984

Facility Name: BARTON W STONE CHRISTIAN HOME

Address: 873 GROVE STREET (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 479- 3400 **Fax #** (217) 243- 8553

IDPA ID Number: 37-0662538-001

Date of Initial License for Current Owners: 5/15/1990

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ken Marx **Telephone Number:** (314-231-5544)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barbara Hannel
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	0	Skilled (SNF)	30	7,710	1
2	0	Skilled Pediatric (SNF/PED)	0		2
3	185	Intermediate (ICF)	155	60,000	3
4	0	Intermediate/DD	0		4
5	24	Sheltered Care (SC)	24	8,784	5
6	0	ICF/DD 16 or Less	0		6
7	209	TOTALS	209	76,494	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,877	2,573	1,036	5,486	8
9	SNF/PED					9
10	ICF	20,590	31,128		51,718	10
11	ICF/DD					11
12	SC			5,940	5,940	12
13	DD 16 OR LESS					13
14	TOTALS	22,467	33,701	6,976	63,144	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.55%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Not applicable

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1959

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 30 and days of care provided 1,036

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	448,608	7,338	6,859	462,805		462,805		462,805			1
2	Food Purchase		363,176		363,176		363,176	(1,094)	362,082			2
3	Housekeeping	261,696	24,465		286,161		286,161		286,161			3
4	Laundry	98,869	13,916		112,785		112,785		112,785			4
5	Heat and Other Utilities			232,791	232,791		232,791	10,335	243,126			5
6	Maintenance	114,505	36,016	96,227	246,748		246,748	(9,256)	237,492			6
7	Other (specify):*											7
8	**TOTAL General Services**	923,678	444,911	335,877	1,704,466		1,704,466	(15)	1,704,451			8
	B. Health Care and Programs											
9	Medical Director					1,000	1,000		1,000			9
10	Nursing and Medical Records	2,713,383	196,709	29,009	2,939,101	(1,000)	2,938,101		2,938,101			10
10a	Therapy		102,532		102,532		102,532		102,532			10a
11	Activities	83,431		920	84,351		84,351		84,351			11
12	Social Services	100,547			100,547		100,547		100,547			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,897,361	299,241	29,929	3,226,531		3,226,531		3,226,531			16
	C. General Administration											
17	Administrative	150,924	8,464	303,418	462,806		462,806	(268,355)	194,451			17
18	Directors Fees											18
19	Professional Services			19,028	19,028		19,028	21,908	40,936			19
20	Dues, Fees, Subscriptions & Promotions			13,801	13,801		13,801	(1,902)	11,899			20
21	Clerical & General Office Expenses	81,997		63,444	145,441		145,441	109,729	255,170			21
22	Employee Benefits & Payroll Taxes			1,343,667	1,343,667		1,343,667	9,747	1,353,414			22
23	Inservice Training & Education			1,704	1,704		1,704		1,704			23
24	Travel and Seminar			3,846	3,846		3,846	29,079	32,925			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			225,076	225,076		225,076	24,186	249,262			26
27	Other (specify):*											27
28	**TOTAL General Administration**	232,921	8,464	1,973,984	2,215,369		2,215,369	(75,608)	2,139,761			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,053,960	752,616	2,339,790	7,146,366		7,146,366	(75,623)	7,070,743			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME #0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			441,610	441,610		441,610	34,031	475,641			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,579	96,579		96,579	(96,579)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,533	14,533		14,533	8,860	23,393			35
36	Other (specify):*											36
37	**TOTAL Ownership**			552,722	552,722		552,722	(53,688)	499,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,554	21,577	30,131		30,131		30,131			39
40	Barber and Beauty Shops	30,773		958	31,731		31,731		31,731			40
41	Coffee and Gift Shops			14,750	14,750		14,750		14,750			41
42	Provider Participation Fee			102,177	102,177		102,177	(611)	101,566			42
43	Other (specify):* **Non Prgrm Exp**	19,932	3,162	33,014	56,108		56,108		56,108			43
44	**TOTAL Special Cost Centers**	50,705	11,716	172,476	234,897		234,897	(611)	234,286			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,104,665	764,332	3,064,988	7,933,985		7,933,985	(129,922)	7,804,063			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,094)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,680)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(108,896)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(611)	42		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,102)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,985)	20		28
29	Other-Attach Schedule	(63,467)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (195,835)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	65,913		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 65,913		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (129,922)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BARTON W STONE CHRISTIAN HOME

ID# 0000984

Report Period Beginning: 1/1/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Shared Admin Salaries	$ (5,719)	17	1
2	Shared Admin Employee Benefits	(1,872)	22	2
3	Shared Maintenance Salaries	(17,924)	6	3
4	Shared Maintenance Employee Benefits	(37,952)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(63,467)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,094)	0	0	0	0	0	0	0	0	0	0	(1,094)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	10,335	0	0	0	0	0	0	0	0	0	10,335	5
6	Maintenance	(17,924)	8,668	0	0	0	0	0	0	0	0	0	(9,256)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,018)	19,003	0	0	0	0	0	0	0	0	0	(15)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(5,719)	(262,636)	0	0	0	0	0	0	0	0	0	(268,355)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,908	0	0	0	0	0	0	0	0	0	21,908	19
20	Fees, Subscriptions & Promotions	(2,985)	1,083	0	0	0	0	0	0	0	0	0	(1,902)	20
21	Clerical & General Office Expenses	(18,782)	128,511	0	0	0	0	0	0	0	0	0	109,729	21
22	Employee Benefits & Payroll Taxes	(39,824)	49,571	0	0	0	0	0	0	0	0	0	9,747	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	29,079	0	0	0	0	0	0	0	0	0	29,079	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	24,186	0	0	0	0	0	0	0	0	0	24,186	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(67,310)	(8,298)	0	0	0	0	0	0	0	0	0	(75,608)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(86,328)	10,705	0	0	0	0	0	0	0	0	0	(75,623)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	34,031	0	0	0	0	0	0	0	0	0	34,031	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(108,896)	12,317	0	0	0	0	0	0	0	0	0	(96,579)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	8,860	0	0	0	0	0	0	0	0	0	8,860	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(108,896)	55,208	0	0	0	0	0	0	0	0	0	(53,688)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	(611)	0	0	0	0	0	0	0	0	0	0	(611)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(611)	0	0	0	0	0	0	0	0	0	0	(611)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(195,835)	65,913	0	0	0	0	0	0	0	0	0	(129,922)	45

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				National Benevolent Association	St. Louis, MO	Division of Social & Health Services of the Christian Church (Disciples of Christ)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$ 303,418	National Benevolent Association	100.00%	$	$ (303,418)	1
2	V	5	Utilities		National Benevolent Association	100.00%	10,335	10,335	2
3	V	6	Maintenance		National Benevolent Association	100.00%	8,668	8,668	3
4	V	17	Administrative		National Benevolent Association	100.00%	40,782	40,782	4
5	V	19	Professional Fees		National Benevolent Association	100.00%	21,908	21,908	5
6	V	20	Dues & Subscriptions		National Benevolent Association	100.00%	1,083	1,083	6
7	V	21	Clerical		National Benevolent Association	100.00%	128,511	128,511	7
8	V	22	Employee Benefits		National Benevolent Association	100.00%	49,571	49,571	8
9	V	24	Seminars		National Benevolent Association	100.00%	29,079	29,079	9
10	V	26	Insurance		National Benevolent Association	100.00%	24,186	24,186	10
11	V	30	Depreciation		National Benevolent Association	100.00%	34,031	34,031	11
12	V	32	Interest Expense		National Benevolent Association	100.00%	12,317	12,317	12
13	V	35	Equipment Rental		National Benevolent Association	100.00%	8,860	8,860	13
14	Total			$ 303,418			$ 369,331	$ * 65,913	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: National Benevolent Association
Street Address: 11780 Borman Dr
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314-812-1791
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Direct Cost	142,894,345	23	$ 199,261	$	7,411,171	$ 10,335	1
2	6	Repairs & Maintenance	Direct Cost	142,894,345	23	167,126		7,411,171	8,668	2
3	17	Administrative	Direct Cost	142,894,345	23	786,321	786,321	7,411,171	40,782	3
4	19	Professional fees	Direct Cost	142,894,345	23	422,412		7,411,171	21,908	4
5	20	Dues & Subscriptions	Direct Cost	142,894,345	23	20,872		7,411,171	1,083	5
6	21	Clerical	Direct Cost	142,894,345	23	2,477,811	2,244,806	7,411,171	128,511	6
7	22	Employee Benefits	Direct Cost	142,894,345	23	955,776		7,411,171	49,571	7
8	24	Seminars	Direct Cost	142,894,345	23	560,672		7,411,171	29,079	8
9	26	Insurance	Direct Cost	142,894,345	23	466,327		7,411,171	24,186	9
10	30	Depreciation	Direct Cost	142,894,345	23	656,153		7,411,171	34,031	10
11	32	Interest Expense	Direct Cost	142,894,345	23	237,474		7,411,171	12,317	11
12	35	Equipment Rental	Direct Cost	142,894,345	23	170,838		7,411,171	8,860	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,121,043	$ 3,031,127		$ 369,331	25

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	1996 Series Bonds		XX	Facility Refinancing & Renovat	$19,591.75	5/1996	$ 3,035,000	$	5/2021	Variable	$ 73,651	1
2	1998 Refinancing Bonds		XX	Refinance Promissory Note	$6,294.92	2/1998	944,834		5/2015	Variable	22,928	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$25,886.67		$ 3,979,834	$			$ 96,579	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,979,834	$			$ 96,579	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BARTON W STONE CHRISTIAN HOME COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0000984

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 191,113 B. General Construction Type: Exterior Brick Frame N/A Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ASA Talcott House, which is a historical structure, a house used by Development, and several cottages and duplexes.
All costs related to these facilities have been reported on cost report line 43 and adjusted to 0.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	325,748		$ 121,684	1
2					2
3	TOTALS	325,748		$ 121,684	3

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1964	1964	$ 369,315	$		$	$	$	4
5			1969	1966	2,236						5
6			1970	1969	491,576						6
7			1990	1970	57,659						7
8	33		1998	1998	2,473,810						8
	Improvement Type**										
9	Various			1970	639,983						9
10	Various			1971	14,949						10
11	Various			1973	22,161						11
12	Various			1976	12,870						12
13	Various			1977	1,661						13
14	Various			1975	154,002						14
15	Various			1991	1,056,337						15
16	Various			1974	457,060						16
17	Various			1978	3,656						17
18	Various			1979	14,306						18
19	Various			1980	8,268						19
20	Various			1981	4,577						20
21	Various			1982	20,064						21
22	Various			1983	512						22
23	Various			1984	2,668,941						23
24	Various			1985	110,535						24
25	Various			1986	29,302						25
26	Various			1987	83,683						26
27	Various			1988	38,037						27
28	Various			1989	32,575						28
29	Various			1992	75,906						29
30	Hockenhull Heating System			1993	181,603						30
31	Hockenhull Shelving Units			1994	24,080						31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Hockenhull Dining Room Expansion	1995	$ 23,635	$		$	$	$	37
38	Carpet, Floor Covering Base	1996	3,945						38
39	Hockenhull Covering and Rails	1996	3,390						39
40	Alarm System	1996	32,351						40
41	Redecorating Hockehull 1 East Hall	1996	3,502						41
42	Hockenhull 1 and II - Tile	1996	3,474						42
43	Hockenhull 1 - Wallpaper	1996	3,240						43
44	Handrails - Younkin Parking Lot	1996	3,658						44
45	Boiler/ HVAC Repairs	1996	14,544						45
46	Electrical Repairs	1996	1,982						46
47	Asbestos Abatement	1996	1,000						47
48	Shower Tile Repair	1996	788						48
49	Masonry - Window/ Garage/ Boiler Room	1996	640						49
50	Patch Walkway Roof Between Hutton/ Younkin	1996	523						50
51	Water heater repair	1996	748						51
52	Disposal for Hutton Kitchen	1996	865						52
53	Hockenhull Wallpaper and Carpet	1997	8,184						53
54	Carpet for Younkin	1997	4,239						54
55	Window treatments - pleated shades	1997	5,948						55
56	Elevator Logic Controls	1997	17,430						56
57	Wanderguard - Resident Security System	1997	9,998						57
58	Hockenhull Water heater	1997	2,770						58
59	Tile Replacement (Hockenhull and Exam Room)	1997	1,224						59
60	Plumbing - Condensing Unit in Younkin	1997	5,530						60
61	Sanitizer	1997	6,319						61
62	Community Room, Activity Room, and PT Room	1997	8,791						62
63	Younkin Basement Stair Door	1997	675						63
64	Parking and Site Work	1997	44,048						64
65	Installation of 2 auto doors with push buttons	1997	4,943						65
66	Parking Lot Lights, Work sout and east	1997	50,939						66
67	Plumbing Work	1997	12,010						67
68	Landscaping	1997	2,206						68
69	Line Work/ Cable Run/ Electric	1997	3,090						69
70	TOTAL (lines 4 thru 69)		$ 9,336,293	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,336,293	$		$	$	$	1
2	Sidewalks	1997	2,758						2
3	Parking Lots and Site Work	1998	101,675						3
4	Additional Building Change Order Costs	1998	153,825						4
5	Boiler/ HVAC Repairs	1998	1,391						5
6	Reroofing North and East	1998	34,646						6
7	Blinds for Dining Room	1998	1,650						7
8	Foundation Leakage	1998	7,770						8
9	Generator Load Panel	1998	5,541						9
10	A/C Compressor	1998	4,594						10
11	Electrical	1998	4,486						11
12	Plumbing and Heating	1998	18,732						12
13	Tree Stump Removal	1998	700						13
14	Cove Base	1998	715						14
15	Carpet- Dining Room- Hockenhull	1999	8,097						15
16	Kitchen Remodeling - Hockenhull	1999	2,367						16
17	Emergency outlets and lighting- Hockenhull	1999	6,104						17
18	Replace Employee Breakroom Floor- Hockenhull	1999	1,099						18
19	Window covering- Hutton	1999	4,229						19
20	Carpet and cove base- Hutton	1999	15,818						20
21	Sewer repair- Hutton	1999	5,314						21
22	Casework Replacement Kitchen- Hutton	1999	7,622						22
23	Smokers Shelter	1999	6,710						23
24	Renovation Younkin (Life Safety, Duct Work, Dampers)	1999	18,107						24
25	Casework Replacement Utility Room - Younkin	1999	22,988						25
26	Window project Hockenhull Bldg	2000	15,000						26
27	Window enlargement Hockenhull Proj Metal Blinds	2000	8,159						27
28	Aluminum Windows Hockenhull Bldg	2000	12,564						28
29	Hockenhull - Tuck Painting, Caulking, Sealing, Masonry/ EL	2000	12,084						29
30	Over bed lights for Hutton Bldg	2000	6,146						30
31	Carpets/ Blinds/ Cabinets/ Elevator Re-working- Younkin	2000	21,640						31
32	Hockenhull Dining Room remodeling project- carpets	2001	7,910						32
33	Upgrade fire alarm system per IDPH survey	2001	2,503						33
34	TOTAL (lines 1 thru 33)		$ 9,859,237	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,859,237	$		$	$	$	1
2	Construction of Pavilion	2002	15,899						2
3	Generator Application, Inspection	2002	3,687						3
4	Mixing Valve, Hockenhull Bldg	2003	4,729						4
5	Power Operation Back Door Hockenhull	2003	3,801						5
6	3 Air handelers, Hock/ Younkin Bldgs	2003	2,768						6
7	6 9000 BTU air handlers for Younkin Bldg	2003	5,864						7
8	2 new computers	2004	1,773						8
9	Implementation of Time Clock	2004	3,780						9
10	Sarita Accuator	2004	1,302						10
11	Sarita Accuator	2004	1,304						11
12	3 Oxygen concentrators	2004	1,913						12
13	Buffet Equipment	2004	815						13
14	Vacuum cleaner	2004	1,999						14
15	Dining room floor on Y2	2004	5,294						15
16	6 air handlers	2004	5,218						16
17	Clothing tag machine	2004	1,343						17
18	3 air units- Younkin	2004	5,064						18
19	Dry Vapor Steamer	2004	1,895						19
20	Chimney on Hutton Bldg repair and replacement	2004	2,850						20
21	Community room concrete work	2004	1,450						21
22	Concrete repairs	2004	600						22
23	Hutton Roof	2004	18,627						23
24	Walk in freezer floor	2004	4,419						24
25	16 Bedside cabinets	2004	2,444						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,958,075	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,958,075	$		$	$	$	1
2	Allocated from NBA	1984	299						2
3	Allocated from NBA	1985	1,042						3
4	Allocated from NBA	1996	21,107						4
5	Allocated from NBA	1994	2,347						5
6	Allocated from NBA	1995	24						6
7	Allocated from NBA	1997	4,510						7
8	Allocated from NBA	1998	74,329						8
9	Allocated from NBA	1999	70,834						9
10	Allocated from NBA	2000	9,750						10
11	Allocated from NBA	2001	2,932						11
12	Allocated from NBA	2002	2,273						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,147,522	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,933,356	$ 441,610	$ 441,610	$		$ 6,091,915	71
72	Current Year Purchases	62,079						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,995,435	$ 441,610	$ 441,610	$		$ 6,091,915	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Van with Lift	2002 Chevy Venture	2002	$ 36,450	$ 3,645	$	$ (3,645)	10	$ 8,201	76
77	Facilities Maintenance	1996 Dodge Truck	1998	13,107				5	13,107	77
78	Patient Services	1995 Chevy Lumina	1998	5,095				5	5,095	78
79	Capitalized Vehicle Rep.	Dodge Truck & Van	2000	3,179				2	3,179	79
80	TOTALS			$ 57,831	$ 3,645	$	$ (3,645)		$ 29,582	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,322,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 445,255	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 441,610	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,645)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,121,497	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage/ Duplex Improvements	$ 55,671	$ 3,718	$ 33,601	86
87	Development Bldg Equip/ Improv	39,263	1,099	39,263	87
88	Grove Development Office	18,327	991	16,400	88
89	Development Vehicle	8,019	802	3,007	89
90					90
91	TOTALS	$ 121,280	$ 6,610	$ 92,271	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 108,113	$	1
2	Cash-Patient Deposits	14,291		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,000)	688,745		3
4	Supply Inventory (priced at)	39,636		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,475		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 852,260	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	2,191		11
12	Long-Term Investments	3,918,277		12
13	Land	148,648		13
14	Buildings, at Historical Cost	10,382,551		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,694,068		16
17	Accumulated Depreciation (book methods)	(6,091,915)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	4,260,222		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,314,042	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,166,302	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 291,310	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,291		28
29	Short-Term Notes Payable	727,060		29
30	Accrued Salaries Payable	638,956		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	29		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,671,646	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,577,191		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		1,246,807		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,823,998	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,495,644	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,670,658	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,166,302	$	48

***(See instructions.)**

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (47,574)	1	
2	Restatements (describe):		2	
3	**To adjust to Unrestricted Fund Balance**	10,096,759	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,049,185	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(378,527)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (378,527)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,670,658	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,383,132	1
2	Discounts and Allowances for all Levels	(1,363,759)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,019,373	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	204,946	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 204,946	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,014	12
13	Barber and Beauty Care	43,221	13
14	Non-Patient Meals	1,094	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	18,711	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 65,040	23
	D. Non-Operating Revenue		
24	Contributions	339,860	24
25	Interest and Other Investment Income***	259,875	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 599,735	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		45,395	28
28a		(379,031)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (333,636)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,555,458	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,704,466	31
32	Health Care	3,226,531	32
33	General Administration	2,215,369	33
	B. Capital Expense		
34	Ownership	552,722	34
	C. Ancillary Expense		
35	Special Cost Centers	132,720	35
36	Provider Participation Fee	102,177	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,933,985	40
41	**Income before Income Taxes (line 30 minus line 40)****	(378,527)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (378,527)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,152	$ 49,124	$ 22.83	1
2	Assistant Director of Nursing	3,996	4,116	42,100	10.23	2
3	Registered Nurses	1,916	20,696	362,041	17.49	3
4	Licensed Practical Nurses	20,696	44,034	699,938	15.90	4
5	Nurse Aides & Orderlies	145,975	150,509	1,397,012	9.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,107	6,464	70,530	10.91	8
9	Activity Director	2,080	2,240	28,703	12.81	9
10	Activity Assistants	6,038	6,532	54,728	8.38	10
11	Social Service Workers	10,135	10,338	100,548	9.73	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,240	31,998	14.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	44,141	45,898	381,283	8.31	15
16	Dishwashers	2,432	2,472	18,091	7.32	16
17	Maintenance Workers	11,206	11,646	114,504	9.83	17
18	Housekeepers	29,195	30,580	261,696	8.56	18
19	Laundry	10,437	10,917	98,869	9.06	19
20	Administrator	2,080	2,080	96,386	46.34	20
21	Assistant Administrator	2,080	2,240	54,538	24.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,248	8,568	81,997	9.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,081	2,201	27,749	12.61	31
32	Other Health Care(specify)					32
33	Other(specify)	7,726	7,726	82,125	10.63	33
34	TOTAL (lines 1 - 33)	320,729	373,649	$ 4,053,960 *	$ 10.85	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	168	$ 6,560	1, 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant		1,190	10, 3	38
39	Pharmacist Consultant		2,046	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,151	10a,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	168	$ 11,947		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Hannel	Administrator		$ 96,386
Mignon Goodpasture	Asst. Administrator		54,538
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 150,924

B. Administrative - Other

Description	Amount
National Benevolent Association- Central Office Cost	$ 303,418
TOTAL (agree to Schedule V, line 17, col. 3)	$ 303,418
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Mare & Company	Audit Fees	5,800
Pranschke & Holderle	Legal Fees	1,739
Rammelkamp Brandney	Legal Fees	1,583
Wells Fargo	Legal Fees	187
Stinson Morrison Heckler LLP	Legal Fees	882
Talx Corporation	Unemployment Consulting	644
C A R F	Consulting	3,667
Various Other	Miscellaneous Professional	4,526
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 19,028

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 316,842
Unemployment Compensation Insurance	31,689
FICA Taxes	299,385
Employee Health Insurance	542,543
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retired Employee Benefits	32,802
Pension Plan	90,385
Group Life Ins	2,500
Employee Recognition	10,216
Group Dental Ins	17,305
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,343,667

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 150)	700
Dues & subscriptions	8,726
Allocated from NBA	1,083
Help wanted ads	1,380
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,889

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 471
In-State Travel	395
Seminar Expense	2,980
Allocated from NBA	29,079
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,925

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BARTON W STONE CHRISTIAN HOME **#** 0000984 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network, Inc., $8,151**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **82,226** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **101,566**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Mare & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.